Penrose (C. B.)

[Reprinted from THE MEDICAL NEWS, March 17, 1894.]

HYSTERECTOMY FOR OTHER CONDITIONS THAN FIBROID AND MALIGNANT TUMORS.[1]

BY CHARLES B. PENROSE, M.D.,
PROFESSOR OF GYNECOLOGY IN THE UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA.

UNTIL very recently the operation of hysterectomy was confined practically to two conditions, malignant disease and fibroma. The improved technique and the admirable results obtained in the modern operation for these conditions have led to its extension to other diseases of the uterus and the appendages. The most radical proposition is: to remove the uterus in every woman in whom it is necessary to remove the uterine appendages. A second less radical proposition may be thus stated: In any case of pelvic disease when there is necessary for cure an operation on the appendages that renders the woman sterile, hysterectomy is a valuable addition to the operation under the following circumstances: when the uterus is diseased; when it is likely to become so; when its removal will facilitate the operation.

I have been following this latter plan since June, 1893, and wish to report my results and conclusions

[1] Read before the College of Physicians of Philadelphia, March 7, 1894.

to the Fellows of the College with the object of obtaining their views upon this new plan of treatment.

The number of cases is not large, but represents a variety of conditions. In a series of seventy-five celiotomies on women for different forms of pelvic disease, exclusive of fibroid and malignant tumors, I have found it of distinct advantage to remove the uterus in fifteen cases, which may be grouped under the following headings:

I. Cases of double salpingitis, generally pyosalpinx, the disease extending into the uterine cornua in the form of a hard cheesy nodule, or an abscess in the uterine tissue; large uterus, chronic metritis and endometritis; profuse irritating vaginal discharge, probably gonorrheal.

II. Cases of salpingitis and ovaritis; flexed or displaced uterus, with or without adhesions; endometritis.

III. Salpingitis of which tuberculosis is the probable cause.

IV. Cases of ruptured tubal pregnancy, of pelvic abscess, or of any accumulation in the pelvis in which the uterus forms part of the wall surrounding the accumulation. The removal of the uterus facilitates the operation and perfects hemostasis.

It must be remembered that in all these cases the uterus was removed as an addition to an operation which rendered the woman sterile. I think that we can consider that the removal of the Fallopian tubes renders the woman sterile, except in very rare instances.

The gonorrheal cases form a large class represent-

ing the most frequent form of salpingitis, and in this disease I think that hysterectomy is a valuable addition to the old operation of simple salpingectomy. In several of the gonorrheal cases my determination to perform hysterectomy was based on the fact that gonococci had been found in the discharge from the os uteri. In others the history of the case and the presence of gonorrheal lesions, such as inflammation of the vulvo-vaginal glands, or their ducts, or urethritis, indicated the gonorrheal origin of the disease, and finally in other cases gonococci were sought for by an assistant in the tubal contents during the operation.

In cases of gonorrheal pyosalpinx the old operation of removal of the tubes relieves the woman from the danger of rupture into the peritoneum. But it does not cure her. The disease continues in the endometrium and in the deeper structures of the uterine wall, often extending from the tubes into the uterine cornua. Careful operators have in these cases been in the habit of removing, by a wedge-shaped amputation, the proximal end of the Fallopian tube. This operation, however, requires almost the same length of time as hysterectomy, and is not followed by perfect hemostasis.

The operation of hysterectomy, however, cures the woman of the leukorrhea which is often the symptom of which she complains the most.

I have tried by all the means devised to cure gonorrheal endometritis, with but very unsatisfactory results. I have never cured it in a case in which pyosalpinx had coexisted. If we leave the uterus in these cases the woman continues to have an irritating

infectious discharge, and she is not considered cured by herself or by her husband.

In posterior displacement, with salpingitis and adhesions to the fundus uteri, removal of the uterus gives more promise of cure than simple removal of the tubes. It is a mistake to suppose that the posterior displacement will remain corrected by the tension of the broad ligaments following a simple salpingectomy. In one case in my series the tubes and ovaries had been removed some years before my operation, and yet the uterus was in a position of extreme retroversion, and the pressure of the fundus upon the rectum caused such pain that for some months before the operation every movement of the bowels had been preceded by a hypodermatic injection of morphin. Hysterectomy stopped the pains and the morphin-habit.

In tuberculous disease of the tubes I think that hysterectomy should always be performed. The investigations of Williams (*Johns Hopkins Hospital Reports*, vol. iii) show that in this disease the uterus and endometrium are affected in from 40 to 60 per cent. of the cases. Unfortunately it is at present impossible to determine the tuberculous character of many cases of salpingitis by the gross appearance at the time of operation, and we are unable to determine the full extension of the disease.

In a case of salpingectomy performed last November the microscope showed tuberculous infiltration in the tubes extending to the plane of section. Had I known this at the time of operation I would have removed the uterus.

In one case of suspected tuberculosis I curetted the uterus and examined the scrapings before the operation and then performed hysterectomy on account of the probable tuberculous character of the endometritis.

The fourth class of cases in which the operation is facilitated by the addition of hysterectomy is illustrated by a case of ruptured tubal pregnancy. The woman had a ruptured tubal pregnancy on the left side. The pelvis was filled with old blood-clot which was walled in by adherent intestines above and by the uterus and broad ligaments in front. The abdominal ostium of the right tube was closed, and the tubes and ovary were bound down by adhesions. In this case the removal only of the blood-clot and as much of the sac as was practicable would have left behind a large bleeding uterus destitute on two-thirds of its surface of any peritoneal covering—and functionally useless when the tubes and ovaries were gone on each side. Its removal, however, enabled me to secure quick and complete hemostasis and to avoid an elaborate drainage of the pelvis.

I know of no way in which the removal of what has been called the emasculated uterus injures the woman. The results in large numbers of hysterectomies for carcinomata and fibromata show that from the mechanical and functional points of view the remaining pelvic contents are uninjured.

Unlike the ovary, the uterus does not seem in any way necessary for the maintenance of womanly traits. I think that, in cases of salpingitis requiring treatment which renders the woman sterile, the re-

moval of the uterus along with the tubes does her less harm, from a psychologic standpoint, than the common operation of removing the ovaries with the tubes. I think that the ovaries, or parts of them, should be left in all cases where practicable, especially in young women.

An objection urged against this form of hysterectomy is the increased danger of the operation. It is undoubtedly true that in some cases the prolonged time of operation, even if only ten or fifteen minutes, may be of serious harm to the woman. In such cases I consider that the operation is improper. The determination to remove the uterus in the class of cases under consideration should depend upon the condition of the woman when she is on the operating-table. If her condition is such that she can endure the increased operation, then I think that hysterectomy is a valuable addition to our treatment in all cases of tubal and ovarian diseases requiring an operation which renders the woman sterile, provided that the uterus is itself diseased to such an extent that it will not readily yield to local treatment; or is so implicated in the pathologic condition in the pelvis that its removal facilitates the performance of a complete operation.

The statistics with which I am familiar show that the removal of the uterus under these circumstances is attended with as small a mortality as the operation of salpingectomy. All the cases in my own experience have recovered.